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Abstract

Aim to explore how adult, child and mental health nursing and midwifery students, selected using multiple mini interviews, describe their ‘values journey’ following exposure to the clinical practice environment.

Background: Values based recruitment incorporates assessment of healthcare students’ personal values using approaches like multiple mini interviews. Students’ experience of adjustment to their values during their programme is conceptualised as a ‘values journey’. The impact of VBR in alleviating erosion of personal values is unclear.

Design A cross-professional longitudinal cohort study was commenced at one university in England in 2016 with data collection points at the end of years one, two and three. Non-probability consecutive sampling resulted in 42 healthcare students (8 adult, 8 child and 9 mental health nursing and 17 midwifery students) taking part.

Methods Six semi-structured focus groups were conducted at the end of participants’ Year One (DC1). Data analysis incorporated inductive and deductive approaches in a hybrid synthesis.

Findings Participants described a ‘values journey’ where their values, particularly communication, courage and wanting to make a difference, were both challenged and retained. Participants personal journeys also acknowledged the: ‘courage it takes to use values’; ‘reality of values in practice’ and ‘need for self-reflection on values’.

Conclusion A ‘values journey’ may begin early in healthcare student’s education programme. This is important to recognise so that appropriate measures are implemented to support students across higher education and clinical practice. Consideration should also be given to the values incorporated in values based recruitment to ensure their fitness for purpose.

Key words: values based recruitment, values, multiple mini interviews, nursing, midwifery, students, values erosion

SUMMARY STATEMENT

Why is this research or review needed?

- Values based recruitment (VBR) approaches are being widely adopted across healthcare student selection processes but there is limited evidence supporting their effectiveness.
- The erosion of personal values in healthcare students once exposed to the pressures of clinical practice are recognised but it is unclear if VBR can alleviate this.
- There is limited published evidence explaining the factors which may have an impact on individuals' ability to provide the care they might previously have aspired to.

What are the key findings?

- Healthcare students report experiencing challenges and changes to their values during the first year of their education programmes.
- Disempowerment may increase the likelihood of healthcare students failing to prioritise their own personal values.
- Despite VBR and selection using multiple mini interviews values attrition may remain significant to healthcare students.

How should the findings be used to influence policy/practice/research/education?

- Re-evaluation of the personal domains values based approaches to healthcare student selection are being designed to assess is suggested.
- Consideration of how healthcare students can be best supported in clinical practice and education settings is necessary.
- Exploration of when education programmes can best invest in implementing measures to encourage and strengthen healthcare students' values as they face the reality of care provision in complex organisations.

INTRODUCTION

Multiple mini interviews (MMIs) are used to inform final decisions in nursing and midwifery student selection processes internationally. As an admissions methodology, MMIs are designed to assess pre-defined attributes and values in a structured way (Eva *et al.*, 2004). In the UK, they have added significance as a selection approach endorsed by Health Education England (HEE) in the national values based recruitment (VBR) programme (HEE, 2014).

The professional and ethical values that inform nursing and midwifery are recognised through ‘Codes of Practice’ (ICN, 2012, ICM, 2013, NMC, 2015). However, the values base of healthcare provision has become a focus of widespread concern (Francis, 2013, McHugh *et al.*, 2013, OECD, 2013). Renewed emphasis has been placed on recruiting the ‘right students’ for nursing and midwifery (WHO, 2016a, WHO 2016b). Selecting such students according to their espoused values is not a new phenomenon; Millar and Bird (2014) suggest it has been integral in admissions processes since the 1970s. In the UK, the national VBR programme aims to select individuals for caring professions based on whether their personal values align with the National Health Service (NHS) Constitution (Great Britain, Department of Health, DH, 2013), Figure 1. However, ‘values based recruitment’ processes (old and new) have been inconsistent across training institutions with a lack of consensus regarding desirable values from which to benchmark selection. This paper discusses the nature of values in the context of VBR. The design, conduct, preliminary findings and implications of a study which aimed to explore the ‘values journey’ of nursing and midwifery students during their education programmes follow.

Figure 1: UK NHS Constitution Values

BACKGROUND

Values are cognitive representations of enduring goals, reflecting personal choice to act in a certain way (Roccas *et al.*, 2002). They shape behaviour and are influenced by motivation (Parks and Guay, 2009). Different values hold different degrees of importance for individuals; a particular value may be important to one person but unimportant to another (Schwartz, 2012). Values can transcend different situations, for example, honesty values may be important to an individual in the workplace as well as with friends or strangers (Schwartz, 2012). They can be prioritised by importance when two or more values are in conflict (Parks and Guay, 2009), for example, individuals may act less benevolently if their achievement values are threatened. Incidences where it would appear patients' needs have not been put first due to possible values choices have been reported in health and social care settings (Keogh, 2013, Francis, 2013, Bentzen et al, 2013).

The UK VBR programme aims to identify those most suited to a career in nursing and midwifery based on the assumption that certain values can be assessed in admissions processes and that values influence behaviour (HEE, 2014). However, simply holding a value or being able to articulate a value does not necessarily mean that an individual's behaviour would always reflect that value (Schwartz, 2012). In addition the merit of VBR can be questioned if values are considered to be fluid and susceptible to change over time and in different situations. (Parks and Guay, 2009). These could be positive or negative iterations where values, values judgements and/or behaviours may be enhanced where altruistic and aspirational values predominate or conversely, values erosion or attrition may take place. Changes in or re-prioritisation of healthcare professional's values have been described in the literature (Paley, 2014). In the UK, this was most notable in the decline in quality and standard of compassionate care identified by Francis (2013). This was in spite of aspirational qualities relating to caring, honesty and justice reported by some nursing students (Feller, 2014). The erosion of personal values due to healthcare organisational pressure is well

documented (Zimmerman, 2005, Hojat *et al.*, 2009, Neumann, 2011, Paley, 2014). Joinson (1992) first reported what she conceptualised as ‘compassion fatigue’ amongst nurses. Maben (2009) later reported that student nurses ideals were compromised or crushed by structural and organisational constraints. Such erosion is more recently described and attributed to the effect of work environments and collegial attitudes by Jack (2017). An increase in cynicism and decrease in idealism is a recognised part of students’ journey through medical school (Hafferty 1991, Feudtner *et al.*, 1994, Drybe *et al.*, 2005, Stratta *et al.*, 2016). The authors conceptualise this ‘movement’ as a ‘values journey’ through which healthcare students might travel during their career progression. It is underpinned by Gadamer’s (1989) theory of ‘horizons of understanding’ towards which individual’s move and which moves with individuals. This fundamental metaphorical movement of human life situates people constantly in flux and changing through interactions with others; in this sense continually re-created through acknowledging the ‘otherness of others’ (Gadamer, 1989).

A negative illustration of this ‘values journey’ is the erosion of nursing and midwifery students values with increased exposure to the clinical practice environment. VBR is the vehicle adopted by the UK government to arrest values attrition through the selection of those most suited to a caring role (DH, 2013). MMIs are one approach being employed by Higher Education Institutions to meet the national VBR agenda. This paper contributes to the very limited published evidence about whether MMIs are effective in a VBR context (Patterson *et al.*, 2014).

Study aim: To explore how adult, child, mental health nursing and midwifery students, selected using MMIs, describe their ‘values journey’ following exposure to the clinical practice environment during their programme.

DESIGN

A cross-professional longitudinal cohort study was commenced at one university in the UK in 2016. The study was designed to explore healthcare students' articulation of their 'values journey' at the end of Years One, Two and Three of their programme using focus groups. This paper presents findings from the end of Year One.

Participants

Using a non-probability consecutive sampling strategy, all September 2016 adult, child, mental health nursing and midwifery under-graduate, pre-registration students were invited to participate. Notably, the midwifery students on this programme had no prior nursing training. Exclusion criteria applied to any volunteer who had previous experience of MMIs or who had undertaken a healthcare education programme before commencing this programme. Students were contacted via email in the first instance and then followed up one week later when they attended university for lectures. Forty two individuals agreed to participate: eight adult, eight child, nine mental health nursing and 17 midwifery students.

Data Collection

Semi-structured focus groups were conducted on two separate occasions at the university. This setting was chosen to avoid distraction and influences from the clinical practice environment (Creswell, 2013). Nursing students attended university on 07.06.16 for one day in their clinical practice placement. Midwifery students had a different programme flow and were not available until the 05.10.16 at which point none had started their second year clinical practice placement. Six focus groups were facilitated lasting between 42 and 58 minutes. For logistical and practical reasons the participants themselves decided which focus groups they would join. Group dynamics can be affected by the heterogeneity or homogeneity of its participants (Krueger and Casey, 2000). It was hoped that this self-selection would encourage freedom of speech (Bazeley, 2000).

Focus groups are synonymous with a dynamic and interactive medium (Wilkinson et al, 2004). It was anticipated that the iterative flow of discussion between participants would generate more meaningful and holistic understanding than 1:1 interviews and new, unexpected insights might be generated (Wilkinson et al, 2004). This reflects the underpinning theoretical positioning of this study which is grounded in the fluid nature of knowledge acquisition (Gadamer, 1989, Evans *et al.*, 2010). In view of the reoccurring themes emerging as the focus groups progressed data saturation (Creswell, 2013) may have been achieved. The authors note that these findings relate to end of Year One experiences; it is anticipated that new insights will follow with data from Years Two and Three once they become available in 2018/2019.

Ethical issues

This study received a favourable decision from the University's Research Ethics Committee in May 2016 (UEC/2016/022/FHMS). A unique code was assigned to each participant. The consent process included agreement for audio-recording of the focus groups. In the event that a volunteer was not willing for their views to be recorded they were unable to participate. This situation did not arise. Informed consent was obtained. The students were advised that their participation or non-participation would have no consequence to their programme progression and that they were free to withdraw at any time.

Analysis

Focus groups were audio recorded, transcribed and uploaded into Nvivo (version 10) for in-depth text analysis and cross referencing between focus groups (Woods *et al.*, 2015). A three-stage hybrid approach (Fereday and Muir-Cochrane 2006) was employed. Initial deductive coding of each focus group was undertaken separately using a codebook (Miles and Huberman, 1994, Crabtree and Miller, 1992) developed *a priori* from the focus group

questions (Stage 1). The codebook acted as a data management tool for organising segments of text (Crabtree and Miller, 1992), it also facilitated transparency in the analysis which enhanced credibility and trustworthiness (Miles and Huberman, 1994). Contextual interpretation of the data using codebook headings in Stage 1 was succeeded by a cross-professional synthesis of all focus group codes in Stage two.

Given the lack of literature exploring healthcare students 'values journey' once selected using MMIs the authors also used a data-driven inductive approach to analysis in Stage three (Boyatzis, 1998, Fereday and Muir-Cochrane, 2006, Creswell, 2013). This hybrid style valued both inductive and deductive approaches by recognising the relative contributions of each towards the knowledge generated.

Study rigour

Focus groups were facilitated by third party researchers to ensure no conflict of interest (Krueger and Casey, 2000). The study PI had personal tutees participating so was prohibited from facilitating the interviews. Focus groups were audio recorded and transcribed verbatim by an external company and data checking of 20% of the transcripts for accuracy and completeness was undertaken by the research team. Each stage was initially completed by one researcher and then verified by a second independent researcher.

FINDINGS

42 volunteers from the 2016 adult, child and mental health nursing and midwifery cohorts took part. Participants ranged in age from 18 to 42 years.

The focus groups revealed detailed information regarding students' awareness of the challenges and changes to their values by the end of Year One of their programmes. Findings are presented to reflect Stages 1-3 of the data analysis. The phrase "all student groups" in this article refers to adult, child and mental health nursing and midwifery participants in the context of this study.

Stage 1

Codes derived from the focus group questions were used to organise the data under the headings A-F, Table 3.

Stage 2

At this stage cross-professional synthesis of coding from Stage 1 revealed six value statements which were central to participants (Figure 2). While there was debate amongst participants about whether communication constituted a ‘value’ or a ‘skill’, it was still regarded as fundamental to their role. All student groups considered integrity and courage important to be trustworthy as well as having a non-judgemental attitude towards patients’ situations. Wanting to make a difference was regarded as a value as well as a personal motivator. Patient empowerment was considered less important in groups such as ‘child nursing’, but considered central to making a difference by the student midwives. The values of treating people with respect and dignity were reported to be vital in all student groups in addition to compassion and empathy. The skill of being able to ‘put yourself in their shoes’ and appreciate patients’ experiences from their perspective appeared to be fundamental to all student groups when providing care.

Stage Three:

At this inductive stage of analysis ten common themes across student groups emerged; these were synthesised into three key themes, Figure 3.

Principle Themes

Theme 1: The courage it takes to use your values

‘Courage’ and needing to ‘stick to your principles and values in challenging situations’ was a reoccurring theme amongst the participants in each focus group. Interpretation of when courage had been demonstrated differed in individual situations and no one student group

showed an overwhelming consensus in terms of a definition of courage. Courage was mainly considered in terms of conserving values or ‘doing what you thought was right’:

“I had a girl who had mental health issues and she confided in me about stuff that had happened in her past. I knew it wasn't right; I was quite clear it wasn't okay...So I spoke with her through that and then afterwards I went to speak to the nurse in charge about what to do with it. Our safeguarding nurse said "... most people might have just ignored it...It was really bright of you to say, because most people might not have had the courage" – CSN1

The need for courage was not only explained from student perspective but also the need to support the principles and beliefs of patients was seen as important. Courage was considered in terms of integrity by upholding professional standards. This was noted to be important to nursing and midwifery student as they valued the role of ‘standing up for someone’.

The notion of integrity was also blended with the courage to demonstrate confidence. Confidence in the role of student, or carer, was seen as being trustworthy and needed, for patients or staff to believe in them. The courage to maintain confidence was considered vital to be able to prioritise and deliver care:

“I think courage is a major one for me personally. I knew that you would be in situation where you would feel like a swan, like really overwhelmed, but externally you need to show that you're okay” – SM1

Student midwives in both focus groups reported to be shocked at the amount of courage they considered necessary every working day. The idea that they needed the courage to act as advocate for the patient against other healthcare professionals to maintain their own integrity, featured highly.

Of the few circumstances where different students had demonstrated courage to speak up, it was consistently due to compromised physical care when planned care had been missed or to explain medical information to patients when they appeared not to have understood:

“I’ve had a lot of safeguarding things with one baby and I’ve had to have the confidence to stand up and say, ‘Look, what’s happening is not right here’. I think how you handle it also depends on what nurse you work with. – CSN1

The lack of courage, or confidence of individuals in the culture and hierarchy of the organisation was noted. Across all student groups, a sense of disempowerment and perceived intimidation was described when faced with speaking up in the presence of more than one doctor. Students were particularly concerned with the potential ramifications of demonstrating courage through voicing a value that questioned care provision. Concerns were mainly directed towards contradicting care provided by those considered more senior to them, which was suggestive of a culture unsupportive of raising concerns. They considered the outcomes to be two fold. Student nurses were more concerned that they would be disciplined through the clinical area contacting the University, while student midwives explained that they were worried that they might damage the relationship they had built up with their mentor by questioning their judgement or care provision:

“For me, if my mentor had said to me, ‘Get him into the living room because we need them all in the living room by 11:00,’ and he doesn’t want to, I’d rather them report me to uni and say, ‘This student is absolutely horrendous and she’s absolutely disrespectful.’ I absolutely don’t mind because as long as I can turn round, look at

that patient and watch him happily eat his meal, I will sacrifice my degree. I don't mind" MHS1.

It appears from these data that courage is an important value but it can be compromised by organisational culture and hierarchy both within and across nursing and midwifery student roles. Students reported a perceived link between courage and confidence which was expected to grow in time. Nursing and midwifery students appreciated the need to display courage to support patients' wishes but expected the consequences to be negative.

Theme 2: The reality of values in practice

Participants, irrespective of student group, felt their values had been challenged in practice when they had witnessed, what they considered to be a lack of care, empathy, dignity and respect:

"I do feel a bit brow-beaten...because you just see other midwives who don't necessarily seem to share the same values that you have. The way they behave around women. You just think, 'I don't want to be that midwife.' But then you understand why. I'm not criticising and they're not bad people and they're not giving bad care, they're just not giving the care that perhaps you in your head thought you would give before you go out and practice." – SM2.

Perhaps unsurprisingly given the disempowerment previously described, only one adult nursing student admitted to challenging the lack of values she witnessed being demonstrated by other staff; in this instance the physical care provided by a support worker. Instead, adult, child, mental health students considered the debasing of their values in practice to be excusable on the grounds of a lack of training or experience. Student midwives, considered the process of reprioritising their values to be an inevitable part of working in the NHS:

“With the older generation of nurses who’ve trained for years, they have their habits and the way they do things... I think in some places that’s the way everyone does it because most of them have probably been working there within the same time frame”

– AS1

Some child nursing students suggested that demonstration of a lack of respect for patients can be caused by work pressures:

“I don’t think to appreciate how hard they are working, in doctors or whoever’s defence... I think it’s just down to time... we see how many patients are on the same ward, but doctors obviously see lots of different patients in different wards”

CSN3.

Student midwives focused on clinical activity levels and the effect such pressures had, suggesting only core values were upheld. These core values were articulated as dignity and respect, but other values were only evident when the clinical activity levels were low enough:

“You wish you had that little bit more time to show that little bit more interest in them.....but I think that’s one major thing that is sometimes the ward activity doesn’t give you the opportunity to show you care as much” – SM3.

All student groups appeared to appreciate a dissonance between the theory and practise of values:

“It was really drummed into us for that essay, as it should be and I feel that it was a little bit, ‘Do as I say, not as I do.’” - SM2.

There appeared to be a consensus that values espoused by the university were the gold standard but after some time in clinical practice midwifery students observed that there was a culture that excused poor values in the face of high activity. Although they stated they wanted to have the time to demonstrate good values, they began to provide their own form of excuse where they prioritised other commitments over values:

“For me in the first year I kind of felt like I was focusing a lot on being compassionate ...I think going into my second year I’m starting to think, ‘I need to focus on competence.’ Not as in I wasn’t competent before, but I’m starting to think, ‘Okay, I think I’ve got that down now [compassionate]. I think I understand how to be nice and I’ve practised being nice for a whole year.’ I think this year my priority will probably be more about competence” – SM4.

The reality of demonstrating values in practice was challenging for all student groups but there was no doubt that demonstrating values was important. Changes in values was justified and explained in terms of the impact of the culture and working environment.

Theme 3: Self-reflection on personal and professional values

Nursing and midwifery students suggested that they had reflected on how their professional experiences influenced their values and described movement in their values or a ‘values journey’. Adult nursing students demonstrated personal insight into how their judgments about others might affect values of respect for others. They recognised this judgment as a potential barrier and were open to change in this behaviour:

“I have found through being on placement how easy it can be to judge somebody but to judge them without realising you’re doing it” – AS2.

Perhaps more worryingly, in relation to the need to adjust values on their 'values journey', all student groups described the need to protect themselves from 'burn out'. Participants considered it important to become resilient, not only the increased clinical work load and university expectations, but also to the perceived diminishing values demonstrated by others in clinical practice:

"A lot of the time when you lose your compassion it is a defense mechanism against working in a very highly stressed, you know, unenjoyable environment. You know, would you rather go home crying every night because you are having to leave these poor people... or you could say, 'XXX this, I am going to look after my mental health and if no-one else is going to care, I am not going to care either'" – AS3.

Protecting emotional wellbeing appeared important when trying to maintain values. However, examples suggested that the protection of individuals' emotional wellbeing might occur at the detriment of care provision:

"A lot of midwives are also protecting their emotional wellbeing by just doing tick box task orientated things in their shifts so when they go home they don't have this big cloud over their head so they can come back in the next day" – SM5.

Faced with such challenges to their original values students reported they had begun to develop strategies to cope:

"But I do think it is important at the end of the day to kind of take a step back. Because that is something I have learned to do now; I was taking it all home with me, I was getting so stressed and het up because I was seeing these people in these

horrible situations and they are massively vulnerable and I had to remember to take a step back....try the best I can do that day” – MHS3.

A theme of disempowerment or powerlessness was elicited amongst nursing and midwifery students in Stage 3. It was suggested that care was being compromised but individuals had limited power to prevent this. They described feeling that they would or had begun to act like the staff they worked with and not in congruence with their personal values. Nursing and midwifery students appeared to be able to reflect on what they considered to be poor care and why they would not like to end up working in that way, however there was a general concern that it may be inevitable.

DISCUSSION

This study aimed to explore changes and challenges to the personal values articulated by adult, child and mental health nursing and midwifery students’ following exposure to the clinical practice environment. Unlike previous work on students’ values, these students were selected to undertake their programme using MMIs. Drawing on Gadamer (1989) we conceptualised the challenges and changes made in their values as a ‘values journey’ where values are fluid and subject to change. All student groups appeared to understand and relate to the phrasing ‘values journey’.

Communication was described as a strong value statement which implicitly underpinned other values. Courage was considered essential by all student groups when trying to implement values in practice. Courage is of course necessary in professional life and is associated with endurance, fortitude, confronting fear and acting ethically in the face of individual vulnerability and institutional fallibility (Banks and Gallagher, 2009). However, evidence of courage being actually applied in the clinical environment was limited in the data. This infers that a challenge to personal values is not withstood by students. Yet at the

same time, participants believed that increasing self-confidence would facilitate the growth of courage in time which infers aspirational changes in values. It will be interesting to explore this further once additional longitudinal data becomes available at the end of students' second and third years.

When students were able to demonstrate courage in situations such as acting as the patient advocate, it was confined to missed physical care. Only one student was able to indirectly challenge care provided by someone they considered senior to them; this was not directly but by escalation through their mentor. It is suggested that organisational structures maybe unsupportive of raising concerns and that significant courage is needed (Nutley and Davies, 2001). This finding raises important questions over prioritisation of values when one or more may be in conflict (Schwartz, 2012, Allan *et al.*, 2016). Allan *et al.* (2017) suggest that disempowerment may increase the likelihood of failing to prioritise one's own personal values.

The organisational culture of healthcare provision appeared to influence values behavior across all student groups. Although the students were aware of some negative consequences of not demonstrating values in practice, this influence was pervasive. These findings concur with previously published evidence of the impact of organisational influences on values behavior (Maben 2009, Paley, 2014, Allan *et al.*, 2016, Kelly, 2016). The shared mental model concerning attitude towards values, reported by students, could reasonably be deduced as indicative of a clinical culture closed to learning and reflection (Senge, 2006, Allan *et al.*, 2011).

The ability to reflect on previous feelings or incidents to learn is essential for personal development (Nutley and Davies, 2001, Evans *et al.*, 2010). Our data suggest that students learnt to change their values when faced with the pressures of clinical activity. All student groups reported aspiring to 'wanting to make a difference' but the 'reality of their values in

practice' was an issue. Perhaps contrary to humanist education philosophy, personal development occurred as they learnt to adapt their values and fit in (Allan *et al.*, 2013).

Although all students are offered support by the University, the impact of witnessing poor demonstration of values in practice resulted in students using resilience techniques to protect their own emotions. In extreme scenarios, this was demonstrated as disengagement which concurs with the findings of Hojat, et al (2009) in their longitudinal study of the erosion of empathy amongst third year medical students. The notion that this situation was not going to get any better was evident as students voiced a general acceptance of the status quo; that it is unchangeable and that their part in it is inevitable.

CONCLUSION

This article presents findings from one university in the UK in relation to what appears to be the start of a 'values journey' or change in individuals' cognisance or expression of their values as they encounter clinical practice pressures. The authors did not want to assume 'values erosion' or 'attrition' but remain open to the data in this previously unpublished context.

These findings are important as they demonstrate that, within one year of commencing their programmes, nursing and midwifery students' values had been challenged. Notably these students had been selected using MMIs in a VBR context i.e. their values were assessed through MMIs to be congruent with the UK NHS Constitution values. VBR is the vehicle through which the UK health service has attempted to arrest values attrition. This suggests that despite VBR and MMI selection, values attrition may remain significant in nursing and midwifery students.

It is anticipated that these insights will encourage wider discourse around three main issues: *what* personal domains values based approaches to student selection, like MMIs, are being

designed to assess and are they fit for purpose? For example should greater priority be given the demonstration of resilience and coping with stressful situations at interview?; *how* healthcare students can be best supported in clinical practice and education settings; *when* education programmes can best invest in implementing measures to encourage and strengthen nursing and midwifery students values as they face the reality of care provision in complex organisations.

These findings are applicable to other cultures and settings given the widespread pressure and generic shortfalls in staff and resources facing healthcare provision (WHO, 2016). The idea that nursing and midwifery students are becoming disenchanted with the reality of sustaining their values in clinical practice so early in their programmes is not easy to hear. It is important for healthcare organisations and education providers to identify how best to aid their students to navigate this environment that they become the next generation of carers able to conserve the values they might previously have aspired to.

Limitations and Recommendations

This study introduces the conceptualisation of a ‘values journey’ for nursing and midwifery students not previously featured in the literature. This could be considered a limitation; the authors however view it is a positive addition to the emerging literature focusing on changes in nursing and midwifery students’ values in a VBR context.

The contextual influences of a single university perspective are acknowledged. The sample size of 42 with representatives across adult, child and mental health nursing and midwifery is considered a strength of the study. Potential limitations associated with the cross-professional synthesis of findings are acknowledged. Applicants to nursing and midwifery programmes at this university are encouraged to have prior care experience. The potential impact of this on their preparedness for the pressures of clinical practice are acknowledged. However, no

participant was included who had started/undertaken a similar programme and therefore had previous experience of clinical practice pressures from a student perspective. End of Year One data is presented; while this is potentially self-limiting the early insight merits further attention. Participants agreed to a three year longitudinal follow up study therefore additional data will become available.

Conflict of interest

None

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